Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
UMESH G. GADARIA, MD, PA

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-2669-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
APRIL 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am sending this Medical Fee Dispute Resolution Request to be reimbursed for my services on 3/13/2014 for surgical procedures that were preauthorized through the insurance carrier and are now being considered 'included in the value of the comprehensive procedure'. First of all, the tendon injuries that were repaired were the comprehensive procedure and therefore listed first on my claim form. The repair to the joint capsule was secondary, which was not even known prior to exploration during surgery. The patient had two tendon injuries that were known prior to surgery and that is what I requested preauthorization for. I did put modifiers on the second tendon repair as well as joint capsule repair for multiple procedures."

Amount in Dispute: $2,400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed Texas Mutual codes 26418, 26418-51, 26530-51, and 64450-51. Review of the NCCI Edits shows codes 26418, 26418-51, and 64450-51 are bundled to 26530 unless a modifier is used. (Attachment) Modifier-51 does not establish a separate service. However, modifier -59 does yet the requestor did not use it with his billing."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 13, 2014	CPT Code 26418 Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon	$1,200.00	$0.00
	CPT Code 26418-51 Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon	$1,200.00	$0.00
Total		$2,400.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-236-This billing code is not compatible with another billing code provided on the same day according to NCCI or Workers compensation state regulations/fee schedule requirements.
   - 435-Per NCCI Edits, the value of this procedure is included in the value of the comprehensive procedure.
   - CAC-193- Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - CAC-W3, 350-In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.
   - 891-No additional payment after reconsideration

Issues

Is the allowance for code 26418 and 26418-51 included in the allowance of code 26530? Is the requestor entitled to reimbursement?

Findings

On the disputed date of service, the requestor billed for the following procedures:

- CPT code 26418 defined as “Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon.”
- CPT code 26530 defined as “Arthroplasty, metacarpophalangeal joint; each joint.”
- CPT code 64450 defined as “Injection, anesthetic agent; other peripheral nerve or branch.”

The respondent denied reimbursement for codes 26418 and 26418-51 based upon reason codes “CAC-236” and “435.”

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

28 Texas Administrative Code §134.203(b)(1) states “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”

Per CCI edits, CPT code 26418 is a component of code 26530; however, a modifier is allowed to differentiate the service. A review of the requestor’s billing finds that the requestor appended modifier “51-Multiple Procedures” to the second CPT code 26418. This modifier is not used to differentiate the service. Therefore, the respondent’s denial is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		01/29/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.